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Difference does not Imply Deviance: Limitations of the use of Standardized Personality Measures for the First Nations Mental Health Patients: A Pilot Study

Elisabeth Haramic

Capella University, Minneapolis, Minnesota

Elisabeth Haramic, Graduate student of Mental Health Counseling at Capella University, Minnesota, Minneapolis. Editor of Special Edition Indigenous Peoples and Suicide, *Archives of Suicide Research*, Assistant Editor *Archives of Suicide Research*, Practicum at Hôtel Dieu Grace Hospital, Outpatient Psychiatry, Windsor, Ontario, Canada and Private practice with Dr. A. A. Leenaars in multicultural translations of personality tests (MMPI-2). Interests include PTSD induced first episode of psychosis in cultural minorities, multicultural counseling and assessment tools. Member of the ACA delegation to China and Mongolia in July 2007.

Rita Sousa

Hôtel Dieu Grace Hospital, Schizophrenia & First Episode of Psychosis Program (SEPP), Windsor, Ontario, Canada

Rita Sousa, Graduate Student of Human Development at Wayne State University, Michigan. Is currently working as a Psychometrist for the Schizophrenia and First Episode Psychosis Program (SEPP) in an inner city metropolitan hospital in Ontario, Canada. Research interests include multicultural counseling, cognitive subtypes of first episode of psychosis and ECT related to declining cognition.

Saadia Ahmad

Hôtel Dieu Grace Hospital, Mental Health Unit, Windsor, Ontario, Canada

Dr. Saadia Ahmad, Clinical Psychology/Clinical Neuropsychology, Director of Psychology Department at Hôtel Dieu Grace Hospital (HDGH), Windsor, Ontario, Canada.

History

First Nations/Alaskan Natives are represented by around 512 tribes and speak more than 200 languages (Allen, 2002). By the end of the eighteenth century only 10% of the original population number remains due to the slaughter and invasion of the Caucasian race. This is one of the cruelest acts upon a people whose land was seized, goods taken away, children removed from their homes and placed with non-Indian families, in the history of humanity (Sue & Sue, 2005). The attempt to “civilize the savages” by assimilating them into the mainstream culture proved a failure. The slow destruction of their culture, beliefs and language resulted in weakening the psychological as well as physical health of this population. Additionally, the mental health emic approach further deteriorated the well-being of the First Nations by imposing ethnocentric values and beliefs onto this population.

Sue and Sue (2005) offer vital health statistical information on the Native Americans as: 1) 50% are unemployed, 2) poverty rate is three times as high, 3) 27% constitute single-mother homes without a father, 4) high rates of obesity, diabetes, and 5) alcohol mortality rate is six times as high then for the remaining U.S. population. Echohawk (2006), further appeals to the American Psychological Association for suicide intervention programs due

to the increasing mortality rates of young male Native Indians. Leenaars, Anawak, Brown, et al. (1999) note that research on suicide among Inuit populations in the 1960s concluded that suicide was a way of life for this population calling it “altruistic” suicide among elders, disabled and the sick as a means of group preservation, however, the rates of suicide escalated among the young males and therefore could not be considered altruistic. However, the results of culturally inappropriate service delivery styles are evident in the underutilization of health services by this population

One of the reasons for underutilization of community health services by the FNs is the potential vulnerability of the FN clients to the predominantly white therapist’s potential biases based on assessment, test content inappropriate standardization samples, measurement of different constructs in different populations, as well as language and social differences with consequences of labeling and prejudice (Kaufman & Reynolds, 1983). All these factors may and do affect the self-report standardized psychological tests, such as the personality measures. Culture-specific responses (emic), styles of interpretation and worldviews may reduce the biases brought upon by the lack of knowledge of the specific culture being examined, therefore, the provision of adequate and valid assessment and intervention services has not been attainable due to biased diagnostic nomenclature, service delivery styles and Eurocentric service personnel (Dana, 2000). Therefore, clinical interpretation on an internal level could be biased towards psychopathology if certain cultural specific factors were neglected.

In contemporary psychology and in today’s society, personality assessment tools, such as

the Personality Assessment Inventory (PAI) and the Minnesota Multiphasic Personality Inventory (MMPI-2) are often utilized under the assumption that they contain few national or cultural boundaries. In accordance with previous research on standardized assessment tools, specifically the personality assessment instruments as it pertains to the FNs; the authors hypothesize that there are elevated sample results on personality disruption, emotional disturbance and poor adjustment among the First Nations, thus, resulting in test bias due to cultural differences that overestimates psychopathology among First Nation populations (Robin, Greene, Albaugh, Caldwell, & Goldman, 2003).

The Cultural Self

The cultural self is comprised of perceptions of reality which compose a worldview (Richard, 2000). The tribe takes on precedence in the lives of the First Nations as the center of the universe. Therefore, the importance of the tribe as a central marker for native mental health has been noted. The native self is fluid including in its boundaries the family, extended family, tribe and community. Sue and Sue point-out six cultural-specific (emic) values in need of attention: 1) sharing, 2) cooperation, 3) noninterference, 4) time orientation, 5) spirituality, and 6) nonverbal communication in First Nations Peoples’.

Hypothesis

In light of the current interest and research in the field of multicultural counseling, we propose that the results obtained through standardized assessment tools are culturally bias, utilizing the PAI as the current tool for demonstration of culturally sensitive and

specific (emic) interpretations on five levels as indicated by Sue and Sue (2005): sharing, non-interference, time orientation, spirituality, and nonverbal communication. Sharing and giving of goods and services leads to the obtainment of honor and respect. Likewise, cooperation among and between members of First Nation tribe's takes priority over the individual, in other words, the tribe and their wants/needs takes precedence over the individuals wants, needs. Non-Interference: it is important to first observe, before reacting impulsively, not interfering with others and respecting the rights of others. Time Orientation: preoccupied with the present and are less involved in planning for the future which is viewed as inconsequential. Spirituality: very important component in the lives of First Nations. The FNs consider the mind, spirit and body as one cohesive unit. Thus, health and/or sickness are based on the harmony or disharmony of these essentials elements (mind, body, spirit). Non-Verbal Communication: First Nations are less likely to ask direct questions. They consider nonverbal communication as a very important component of learning. Learning is based more on listening and less on talking.

Method

Participants

The presented pilot study utilized five inpatient clients. There were three males and two female participants aged 18 to 44 (Table 1).

Procedure

A case by case examination was conducted to test the hypothesis and to provide a clearer understanding of the clinically elevated scales for the First Nations on the PAI. The

consent for services was obtained voluntarily and the data was collected. The PAI was chosen as the measure of personality since it is widely employed by the public hospitals mental health department. Furthermore, the PAI has shown persistent validity throughout recent research when employed in measures of psychopathology within this population. The five participants were selected on the basis of spontaneous identification with a minority status, namely the First Nations. An extensive unstructured clinical interview conducted by a licensed Psychologist, asked: "Paint a picture of who you are" during which the participants identified spontaneously by inertly stating First Nations membership. All of the five participants presented at the inpatient mental health unit in an inner city metropolitan Hospital. The participants were evaluated cognitively on the basis of an extensive neuropsychological assessment battery, followed by the administration of a personality measure, namely the PAI. A clinical assessment document review and added assessment by a Psychiatrist were conducted for the purpose of diagnosis, the diagnosis was agreed on by the Psychiatrist and the Psychologist working with the participants.

The authors looked at the responses individually noting the elevated raw and T-scores for clinical scales and subscales. The authors researched the scores related to personality disorders, emotional instability and poor adjustment. The presented pilot study utilized a cut-off point at (+/-) two standard deviations above the mean.

Results

Participant 1

In reviewing the T-scores across all scales, participant one attained an elevated ($T = 83$; $SD = 3$) on the psychotic experience subscale, of the schizophrenia scale (Table 2). This clinical detailed procedure did not support any clinical history of Schizophrenia, the diagnosis of PTSD, Major Depression and Generalized Anxiety Disorder was concluded.

Participant 2

In reviewing the T-scores across all scales, participant two attained an elevated ($T = 76$; $SD = 2$) on the schizophrenia scale and ($T = 74$; $SD = 2$) on the borderline scale (Table 2). Diagnosis: Adjustment Disorder with Depressive Features, ruling out Mixed Personality Disorder.

Participants 3

In reviewing the T-scores across all scales, participant three attained an elevated ($T = 70$; $SD = 2$) on the affective subscale, of the anxiety scale and ($T = 72$; $SD = 2$) on the physiological subscale, of the anxiety scale. In examining related anxiety related disorder scale, participant three had an elevated score of ($T = 75$; $SD = 2$) on the traumatic stress subscale. Participant three also had an elevated score on the depression scale with ($T = 78$; $SD = 2$) on the cognitive subscale and ($T = 72$; $SD = 2$) on the affective subscale. Participant three also presented with elevated scores on the paranoid scale with ($T = 75$; $SD = 2$) on the hyper-vigilance subscale and ($T = 72$; $SD = 2$) on the persecution subscale. Likewise, participant three presented elevated scores on the borderline scale with ($T = 72$; $SD = 2$) on the affective instability subscale and ($T = 75$; $SD = 2$) on the negative relations subscale (Table 2). The final diagnosis as confirmed by a battery of

neuropsychological tests and psychiatric evaluation based on the DSM-IV-TR structured interview was PTSD, no personality disorder.

Participant 4

The results indicated that participant four presented some elements of exaggeration of complaints with ($T = 72$; $SD = 2$) on the Negative Impression Scale (NIM). Thus, caution is required in interpretation of all scores. However, in viewing the T-scores across all scales, participant four attained an elevated ($T = 79$; $SD = 2$) on the antisocial behavior subscale, of the antisocial scale. Participant four also had an elevated score of ($T = 73$; $SD = 2$) on the stimulus seeking subscale of the antisocial scale (Table 2).

Diagnosis: PTSD and antisocial Personality Disorder.

Participant 5

The results indicated that participant five presented some elements of exaggeration of complaints with ($T = 84$) on the Negative Impression Scale (NIM). Thus, caution is required in interpretation of all scores. However, in viewing the T-scores across all scales, participant five attained an elevated ($T = 75$) on Somatic conversion complaints ($SD = 2$). In examining the anxiety scale responses, the participant responded with ($T = 75$; $SD = 2$) in the affective subscale, ($T = 87$; $SD = 3$) and ($T = 92$; $SD = 4$) on the physiological subscale. Likewise, on the anxiety related disorders scale, participant five attained ($T = 70$; $SD = 2$) on the obsessive-compulsive subscale and ($T = 87$; $SD = 3$) on the traumatic stress subscale. Participant 5 also presented elevated scores on the depression scale with ($T = 88$; $SD = 3$) on the affective subscale and ($T = 82$; $SD = 3$) on

the physiological subscale of depression. The participant also presented an elevated score of ($T = 78$; $SD = 2$) on the irritability subscale of the mania scale. The participant also presented ($T = 99$; $SD = 4$) on the thought disorder subscale of the Schizophrenia scale. Furthermore, participant five presented elevated scores on the borderline scale with ($T = 81$; $SD = 3$) on the affective instability subscale and ($T = 86$; $SD = 3$) on the identity problem subscale. Lastly, participant five presented elevated scores on the aggression scale, with ($T = 8$; $SD = 81$) on the aggressive attitude subscale, ($T = 7$; $SD = 2$) on the verbal aggression subscale and ($T = 100$; $SD = 5$) on the physical aggression subscale (Table 2). Diagnosis: PTSD.

Discussion

In order to work successfully with any culturally diverse population, the mental health provider is required to administer culturally and ethically sensitive personality and intervention assessment tools. Likewise, the mental health provider has to be aware of their own impeding cultural values and beliefs, while adhering to the client's value system. Both counselor and client need to have a strong sense of racial identity development at a progressive level (Helms, 1984). The research presented used a community-based, collaborative and participatory approach highlighted by Caldwell, Jamie and Du Bois et al. (2004) as a foundation to culturally sensitive and competent research practice that take culture as an essential context in research.

The long standing recognition by mental health providers for testing the generalizability of test findings with minority populations while avoiding assumptions of comparative

results irrespective of culture and ethnic status has become reality (Rogers, Flores, Ustad, & Sewell, 1995). Additionally, the Codes of Ethics (E.8.) and (E.9.a.) (ACA, 1995) by which mental health providers abide highlight the importance of assessment limitations due to race, culture and ethnicity. Therefore, the presented pilot study explored the established hypothesis that minority members, specifically the First Nations, would present with elevated scores on clinical scales of personality measures such as the Personality Assessment Inventory (PAI) due to culturally-specific constructs as defined by Sue & Sue (2005). The level of acculturation was taken into consideration by indicating culture as a relevant factor spontaneously in the clinical interview administered by the psychologist.

Personality Disruption

According to the results obtained, the participants have indicated elevated sample results on personality disruption, emotional disturbance and poor adjustment. In regards to personality disruption, several participants (2, 3, 4 and 5) obtained elevated scores. On borderline scales, specifically along the affective instability, negative relationships and identity problems subscales participants (2, 3, and 5) obtained elevated scores. Thus, several participants have heightened emotional responses, often feel betrayed by loves ones and/or are unsure about life issues and typically feel empty inside or unfulfilled. Participant three had elevated scores on the paranoid scale, with feelings of being treated unfairly, and more likely to monitor “their environment for evidence that others are trying to harm or discredit them in some devious way” (Morey, 1991, p. 71). Participant four

had elevated scores on the antisocial behavior subscale. This indicates that participant four may have a history of deviant and possibly illegal antisocial acts, such as, destruction of property. Likewise, participant four also had elevated scores on the stimulus-seeking subscale of the antisocial scale. Individuals with elevated scores on this subscale are likely to participate in dangerous behavior and hunger for excitement.

Emotional Disturbance and Poor Adjustment

In regards to emotional disturbance, several participants (1, 2, 3, and 5) obtained elevated scores. Participants 3 and 5 obtained elevated scores on the anxiety scale, the anxiety related disorders scale, and the depression scale. Furthermore, participant 5 also had elevated scores on the mania scale the aggressions scale and the schizophrenia scale. Participants 1 and 2 also had elevated scores on the schizophrenia scale. Thus, there are elements of concern regarding current situations, feelings of tension, somatic stress, rigid behavior, feelings of being damaged due to past experiences, as well as feelings of hopelessness, sadness, and changes in physical functioning. There are also possible feelings of irritability that others do not understand their plans, difficulties in concentrating verbal aggression, physical aggression and being easily angered. All of these personality disruptions and emotional disturbances negatively impact an individual's ability to function, resulting in poor adjustment and coping.

Based on the preliminary findings of the presented pilot study suggestions for further research include a comparison quantitative study of a larger number of First Nations participants compared to non-First Nations participants on the PAI. The limitations of the

presented study are numerous. Firstly, the pilot study was limited to a qualitative case study utilizing only five participants and therefore cannot be generalized to the greater First Nations population. Secondly, the participants were chosen based on the premises that they identified spontaneously with their culture of origin and therefore were considered to be at a lower level of acculturation into the mainstream population. The level of acculturation should be tested separately and identified accurately. Thirdly, the population was limited to the inpatient status and therefore, due to severe psychopathology should not be generalized to the greater First Nations population.

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Table 1

Demographics of case by case study

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Gender	Female	Female	Male	Male	Male
Age	40	18	40	44	37

Table 2

Significant T-scores of the five participants along all significant scales and subscales

PARTICIPANTS	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
	1	2	3	4	5

T-Scores			
NEGATIVE IMPRESSION SCALE			84
SOMATIC			
ANXIETY	Conversion		75
	Cognition		87
	Affective	70	75
	Physiological	72	92
ANXIETY RELATED DISORDERS			
	Obsessive-Compulsive Disorder		70
	Traumatic Disorder	75	87
DEPRESSION			
	Cognitive	78	93
	Affective	72	88
	Physiological		82
MANIA			
	Irritability		78
PARANOID			
	Hypervigilance	75	
	Persecution	72	
SCHIZOPHRENIA		76	
	Thought Disorder		99
	Psychotic Experience	83	
BORDERLINE		74	
	Affective Instability	72	81
	Negative Relationships	75	
	Identity Problems		86
ANTISOCIAL			
	Antisocial Behavior	79	
	Stimulus-Seeking	73	
AGGRESSION			
	Aggressive Attitude		81
	Verbal Aggression		71
	Physical Aggression		100

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